

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39228

STATE FILE NUMBER

FILED DEC 9-1957

Registration District No.

42

Primary Registration District No.

1000

Registrar's No.

1328

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St Joseph</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SAVANNAH</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Methodist</u>				Length of stay in lb <u>2 1/2 days</u>		d. STREET ADDRESS (If outside, give location) <u>208 W Chestnut</u>	
3. NAME OF DECEASED (Type or print) First <u>Hospital</u> Middle <u>Hugh</u> Last <u>Leper Brown</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 29-1885</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>71</u>	
11. BIRTHPLACE (City and state or country) <u>St. Joseph Mo</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13a. FATHER'S NAME <u>Felix Brown</u>				13b. MOTHER'S MAIDEN NAME <u>Un Known</u>		14. NAME OF HUSBAND OR WIFE <u>Alice Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>507-16-1521</u>		17. INFORMANT <u>Mrs. Alice Brown</u> Address <u>SAVANNAH Mo</u> <u>208 W Chestnut</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Hypertrophy of Prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>60 hours</u>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>tree limb fell on head.</u>			
20c. TIME OF INJURY Hour <u>11:30</u> Month <u>11</u> Day <u>23</u> Year <u>57</u> a.m. <u>PM</u>							
20d. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at work.</u>		20f. CITY, TOWN, OR LOCATION <u>Savannah, Mo.</u>		20g. COUNTY <u>Andrew</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>10-24-57</u> to <u>11-25-57</u> and last saw him alive on <u>11-25-57</u> Death occurred at <u>9:35 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Arthur O. Baker M.D.</u>				22b. ADDRESS <u>Savannah, Missouri</u>		22c. DATE SIGNED <u>11-26-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-30-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SAVANNAH</u>		23d. LOCATION (City, town, or county) (State) <u>SAVANNAH Mo</u>	
24. FUNERAL DIRECTOR <u>Breit Funeral Home</u>				25. DATE RECD. BY LOCAL REG. <u>Dec 2, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Robert Fulton</u>	

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Louanna, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.